The changing perceptions of sex and sexuality

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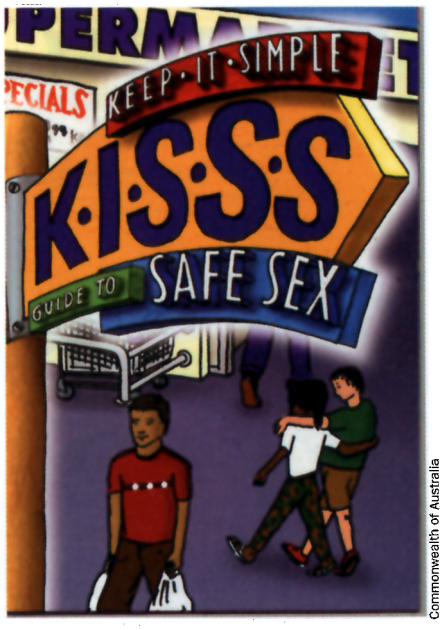
Sex and sexuality have long occupied centre stage in western discourse, yet until recently, sexual health has been a public-health Cinderella. If attention *was* paid to sexual health, it was cast as a disease, with a small band of medical specialists—venereologists in particular—charting and attempting to reduce the prevalence and incidence of sexually transmissible infections (STIs). Meanwhile, sexologists, in the wake of Richard von Krafft-Ebing, Henry Havelock Ellis, and Alfred Kinsey, counted and recounted the behaviours of sex, establishing sexual "norms" and an ever-growing list of deviant exceptions to them.

After World War II, there was a shift to a broader consideration of sexuality, in part driven by a concern over world population growth. Subsequently, we began to focus on sexuality within the context of women's and men's health—a result, in part, of the development of second-wave feminism and gay-liberation politics. The move was exemplified in the broadened agenda of the International Conference on Population and Development in 1994 (the Cairo Conference). There, a new approach to sexual and reproductive health focused attention on previously ignored and socially sensitive issues such as gender relations, male involvement in fertility, contraception and abortion, and the sexual and reproductive health needs of young people, including sex education.



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Teaching about sexual health
Cover of a booklet distributed to Australian adolescents.

An even bigger impetus for broadening the sexual-health agenda has come from the HIV/AIDS pandemic. Just as fertility cannot be separated from women's and men's broader sexual interests, HIV/AIDS cannot be seen merely as a dangerous viral infection. The social, economic, and cultural forces that frame people's lives powerfully influence sex practices, sexual cultures, and individual and group responses to preventive-health messages. For example, to understand why young women use condoms less frequently with casual than with regular male partners, we need to take into account the dynamics of gender and power. If we want to understand why young men are encouraged to seek sexual experience (whereas young women remain virgins), we need to consider how historical and social forces produce and sustain this difference in the face of HIV/AIDS and STIs. Similarly, we now know that the western classification of the "homosexual" as a type of person is not easily transferred to most less-developed countries (even if the same sexual practices occur). This has challenged western science's culturally bound sexological categories and forced recognition that sexual health, in this instance, is not merely about correcting sexual "pathology".

The increased interest in the social determinants of sexual health has reduced medical hegemony in this area. Many research centres now have social and behavioural researchers working collaboratively with clinicians and epidemiologists, in recognition that there needs to be a collective cross-disciplinary understanding of sexual health and how to achieve a sexually healthy population. In pursuing this goal, Australia (like the UK) is now developing a national sexual-health strategy. However, the Australian strategy is based on an extant national HIV/AIDS strategy, which is currently in its fourth version. Since Australia's first strategy was produced in 1989, we have learned a great deal about collaborative partnerships between government, communities, researchers, and those with a legitimate voice, including people living with HIV infection and AIDS. There has also been a balance between resources spent on treatment of illness and disease, and that spent on prevention and health promotion. The successive strategies supported multisectoral partnerships across government departments, a multidisciplinary biomedical and social research agenda, cooperation between clinicians and affected communities, and involvement of the private sector. The success of Australia's HIV/AIDS strategies has prompted the application of similar principles to the development of a national sexual-health strategy. An effective strategy will need to include the health sector and a realignment of existing resources, but also welfare, justice, and education. For example, it must grapple with the sensitive issue of sex education in schools. Despite substantial evidence for the positive effects of sex education, there is still some reluctance to grasp this particular nettle. Or, if sex education is introduced, the emphasis is on abstinence (as in the USA) rather than harm reduction, despite compelling evidence that many young people are sexually active by their early teens and express strong ownership of their sexual interests.

Finally, a comprehensive sexual-health strategy will have to take into account not only the culturally sensitive concepts of sex and sexuality, but also recognise the impact of sexual globalisation. By this we mean that today's sexual reality includes frequent and readily shared images of sex via the internet, music videos, films, magazines, and so on. Sex is not just socially produced—social life is increasingly sexual. While the rapid spread of drug-resistant STIs and HIV threatens to refocus attention on diseases, a return to a narrow biomedical vision will not enhance sexual health.

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